Coverage Comparison
HMO vs Traditional

Services:	**HMO**	**TRAD < 25K**	**TRAD 25K-35K**	**TRAD > 35K**
Prescription Deductible: Single/Family	$0/$0	$25/person	$25/person	$25/person
Deductible Single/Family	$0/0	$0/0	$125/400	$500/1000
Primary Care Physician (office visit)	$5	20/40	20/40	20/40
Specialist (e.g., Surgeon, Psychiatrist)	$10	20/40	20/40	20/40
Allergy Testing (Only prepackaged allergy medicines requiring a prescription will be covered under prescription drug section. Serums are not covered under the prescription drug section)	$0	20/40	20/40	20/40
Inpatient Services (Including covered transplants)	$0	20/40	20/40	20/40
Outpatient Services	$0	20/40	20/40	20/40
Skilled Nursing Facility	$0	Not covered	Not covered	Not covered
Home Health	$0	20/40	20/40	20/40
Hospice	$0	20/40	20/40	20/40
Urgent Care (in/out)	$10/$25	20/40	20/40	20/40
Emergency Room (in/out)	$10/$25	20/40	20/40	20/40
Casts and Dressings	$0	20/40	20/40	20/40
Durable Medical Equipment	$0	20/40	20/40	20/40
Prosthetics (Initial purchase, fitting, repair and one replacement per contract year or as medically necessary)	$0	20/40	20/40	20/40
Alcohol & Drug Addiction (out)	$20	20/40	20/40	20/40
Physical Therapy (requires referral & prior approval)	$0	20/40	20/40	20/40
Speech Therapy (requires referral & prior approval)	$0	20/40	20/40	20/40
Occupational Therapy (requires referral & prior approval)	$0	20/40	20/40	20/40
Mental Health Therapy (requires referral & prior approval)	$0	20/40	20/40	20/40
Hearing Tests	$0	Not covered	Not covered	Not covered
TMJ (Treatment approved by PCP and Health Plan Director; due to injury or medical condition; no dental services)	$0	20/40	20/40	20/40
Prescription Drugs (30 days)				
Generic Formulary	$5	10%	10%	10%
Brand Name Formulary	$10	20/40	20/40	20/40
Generic Non-Formulary	$15			
Brand Name Non-Formulary	$20			
Birth Control Pills	$5	Not covered	Not covered	Not covered
* If the cost of the prescription is less than the co-pay the employee pays only the lesser amount.				
Family Planning				
Fertility Counseling & Testing	20%	Not covered	Not covered	Not covered
Vasectomy	20%	20/40	20/40	20/40
Tubal Ligation	20%	20/40	20/40	20/40
IUD	20%	Not covered	Not covered	Not covered
Benefits required under IC 5-10-8, IC 27-8, IC 27-13 and 42 CFR 417.101				
Out-of-pocket (in-network) Single/Family	$1000/2000 annually	$1000/2400 annually	$1000/2400 annually	$1000/2400 annually
No pre-existing condition exclusions				

*Refer to Benefit Summaries for additional information.